		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011288

Facility Name: Marklund Children's Home

Address: 164 S. Prairie (Number) Bloomingdale, IL (City) 60108 (Zip Code)

County: DuPage

Telephone Number: (630)529-2018 **Fax #** (630)529-9128

IDPA ID Number: 36-2652532

Date of Initial License for Current Owners: 10/1/68

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501-(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lisa Lipira **Telephone Number:** (630)529-2018 Ext. 2232

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/01 to 6/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Lisa Lipira

(Title) CFO & Vice President, Finance and Administration

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/11/00

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	29,734	1,480		31,214	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,734	1,480		31,214	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.02%

D. How many bed-hold days during this year were paid by Public Aid?
930 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/1/68

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 7/1/01-6/30/02 Fiscal Year: 7/1/01-6/30/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 7/1/01 **Ending:** 6/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	226,335	14,657	17,112	258,104		258,104		258,104			1
2	Food Purchase		225,817		225,817		225,817		225,817			2
3	Housekeeping	100,771	34,776		135,547		135,547		135,547			3
4	Laundry	73,062	21,274		94,336		94,336		94,336			4
5	Heat and Other Utilities			148,714	148,714		148,714		148,714			5
6	Maintenance	61,709	29,782	65,859	157,350		157,350		157,350			6
7	Other (specify):*			27,415	27,415		27,415		27,415			7
8	**TOTAL General Services**	461,877	326,306	259,100	1,047,283		1,047,283		1,047,283			8
	B. Health Care and Programs											
9	Medical Director			32,267	32,267		32,267		32,267			9
10	Nursing and Medical Records	2,367,342	241,847	149,659	2,758,848	(52,936)	2,705,912		2,705,912			10
10a	Therapy	246,799	10,793	37,404	294,996		294,996		294,996			10a
11	Activities		29,819	5,087	34,906		34,906		34,906			11
12	Social Services	46,966			46,966		46,966		46,966			12
13	Nurse Aide Training		2,985		2,985	52,936	55,921		55,921			13
14	Program Transportation			59,261	59,261		59,261		59,261			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,661,107	285,444	283,678	3,230,229		3,230,229		3,230,229			16
	C. General Administration											
17	Administrative	132,706	130,118		262,824		262,824		262,824			17
18	Directors Fees											18
19	Professional Services			10,349	10,349		10,349		10,349			19
20	Dues, Fees, Subscriptions & Promotions			64,119	64,119		64,119		64,119			20
21	Clerical & General Office Expenses	284,780		61,953	346,733	(9,536)	337,197		337,197			21
22	Employee Benefits & Payroll Taxes			820,220	820,220		820,220		820,220			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,589	7,589		7,589		7,589			24
25	Other Admin. Staff Transportation			22,934	22,934		22,934		22,934			25
26	Insurance-Prop.Liab.Malpractice			64,243	64,243		64,243		64,243			26
27	Other (specify):* **Fundraising/Promo**			1,088,860	1,088,860		1,088,860	(1,088,860)				27
28	**TOTAL General Administration**	417,486	130,118	2,140,267	2,687,871	(9,536)	2,678,335	(1,088,860)	1,589,475			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,540,470	741,868	2,683,045	6,965,383	(9,536)	6,955,847	(1,088,860)	5,866,987			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Marklund Children's Home #0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			2,259	2,259	9,690	11,949	(11,949)				33
34	Rent-Facility & Grounds			9,690	9,690	(9,690)						34
35	Rent-Equipment & Vehicles					9,536	9,536		9,536			35
36	Other (specify):* Depreciation			371,052	371,052		371,052	(111,823)	259,229			36
37	**TOTAL Ownership**			383,001	383,001	9,536	392,537	(123,772)	268,765			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	289,080	85,933		375,013		375,013		375,013			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			323,061	323,061		323,061		323,061			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	289,080	85,933	323,061	698,074		698,074		698,074			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,829,550	827,801	3,389,107	8,046,458		8,046,458	(1,212,632)	6,833,826			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(111,823)	36		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,088,860)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real Estate Taxes	(11,949)	33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,212,632)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,212,632)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Marklund Children's Home

ID# 0011288

Report Period Beginning: 7/1/01

Ending: 6/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Real Estate Taxes on Rented site	$ (11,949)	33	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(11,949)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):* **Fundraising/Pron**	(1,088,860)	0	0	0	0	0	0	0	0	0	0	(1,088,860)	27
28	**TOTAL General Administration**	(1,088,860)	0	0	0	0	0	0	0	0	0	0	(1,088,860)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,088,860)	0	0	0	0	0	0	0	0	0	0	(1,088,860)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Marklund Children's Home** **# 0011288** **Report Period Beginning:** **7/1/01** **Ending:** **6/30/02**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(11,949)	0	0	0	0	0	0	0	0	0	0	(11,949)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):* **Depreciation**	(111,823)	0	0	0	0	0	0	0	0	0	0	(111,823)	36
37	**TOTAL Ownership**	(123,772)	0	0	0	0	0	0	0	0	0	0	(123,772)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,212,632)	0	0	0	0	0	0	0	0	0	0	(1,212,632)	45

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	None								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	None					$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	None						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	None											6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10	None											10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	N/A	8
	1998		9
	1999		10
	2000		11
	2001		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Children's Home COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0011288

CONTACT PERSON REGARDING THIS REPORT Lisa Lipira

TELEPHONE (630)529-2018 Ext. 2232 FAX #: (630) 529-9128

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-14-301-031	90 bed facility-tax exempt	$ None	$ None
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? N/A YES N/A NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,216 B. General Construction Type: Exterior Brick Frame Cement/Cinder Block Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	206,930	1968	$ 31,500	1
2					2
3	TOTALS	206,930		$ 31,500	3

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1968	1953	$ 68,500	$	33	$	$	$ 68,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Pavillon land impr			1989	6,485	324	20	324		4,377	9
10	Landscaping land impr			1990	1,080		10			1,080	10
11	Asphalt Paving Land impr			1991	7,112		5			7,112	11
12	Asphalt Seal & Strip Parking Lot land impr			1994	14,893		5			14,893	12
13	Asphalt Land impr			1996	800	80	5	80		800	13
14	Seal & Repair Driveway Land impr			1998	600	120	5	120		420	14
15	Parking Lot Concrete Asphalt land impr			1999	300	60	5	60		150	15
16	Parking Lot Concrete Asphalt land impr			1999	32,199	6,440	5	6,440		1,610	16
17	Removal of ramp & installation of new land impr			1999	2,100	420	5	420		1,050	17
18	Parking Lot Concrete Asphalt land impr			2000	300	60	5	60		150	18
19	Resurface Playground land impr			2000	7,750	1,550	5	1,550		2,325	19
20	Sealcoat & Striping of Parking lot land impr			2000	3,187	637	5	637		956	20
21	Safety Surfacing of Playground			2000	6,094	1,219	5	1,219		1,828	21
22	Landscaping of Playground land impr			2000	3,325	665	5	665		998	22
23											23
24	Building Construction Pod II			1973	615,786	17,009	40	17,009		454,182	24
25	Oxygen Work			1974	74,064	2,047	40	2,047		52,563	25
26	Oxygen Work			1975	5,000	135	40	135		3,446	26
27	Oxygen Work			1976	7,535	188	40	188		5,038	27
28	New Roof			1986	81,000	4,050	20	4,050		66,825	28
29	Lobby Addition			1984	108,605	5,030	25	5,030		80,939	29
30	Parents Room			1987	42,000	2,100	20	2,100		30,450	30
31	POD general renovations floors/walls			1992	22,173	1,164	10	1,164		21,923	31
32	Fire Alarm			1993	850	85	10	85		85	32
33	Oxygen System			1993	13,429	1,343	10	1,343		1,343	33
34	Carpeting			1995	2,984	298	10	298		2,238	34
35	Water Heaters			1995	8,916	892	10	892		6,687	35
36	Vinyl Tile			1995	644	64	10	64		419	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	new compressor	1999	$ 2,580	$	15	$	$	$	37
38	Awnings	1999	2,520		5				38
39	Boiler	1998	2,675		5				39
40	Lobby walls	2000	57	12	5	12		29	40
41	Awnings rear entrance	2000	2,023	405	5	405		1,012	41
42	lower level classroom renovations	2000	189	37	5	37		91	42
43	awning for O2 protection	2000	3,477	695	5	695		1,739	43
44	Lobby walls	2000	4,997	999	5	999		2,499	44
45	HVAC-dining room	2000	610	122	5	122		305	45
46	Dining room walls & wall coverings	2000	2,060	412	5	412		1,030	46
47	HVAC coil dining room	2000	1,590	318	5	318		795	47
48	fire doors lower level	2000	564	56	5	56		141	48
49	carpet flooring lower level	1999	5,855	1,171	5	1,171		2,928	49
50	lower level classroom renovation	1999	1,346	269	5	269		673	50
51	replacement windows	1999	538	108	5	108		269	51
52	Construction, engineering, architect, inspection	1999	49,390	4,939	10	4,939		12,348	52
53	fire sprinkler system	1999	72,843	2,914	25	2,914		7,284	53
54	interior design, handrails, corner pieces	1999	29,873	1,992	15	1,992		4,979	54
55	Demolition old lower level	1999	26,641	2,664	10	2,664		6,660	55
56	Chair rails	1999	8,160	1,632	5	1,632		4,080	56
57	Wall Carpet	1998	4,887	977	5	977		3,421	57
58	Painting lower level	1999	19,835	3967	5	3,967		9,918	58
59	lower level construction walls	1999	101,713	10171	10	10,171		25,428	59
60	cabinets	1999	46,002	3,067	15	3,067		7,667	60
61	Reg. & auto doors	1999	18,259	1,826	10	1,826		4,565	61
62	Equip relocation	1999	2,495	499	5	499		1,248	62
63	Electrical work lower level	1999	29,697	2,970	10	2,970		7,424	63
64	windows/shutters	1999	15,523	1,553	10	1,553		4,659	64
65	Floor/carpeting	1999	46,503	9,301	5	9,301		23,251	65
66	Signage Interior/Exterior	1999	3,899	390	10	390		975	66
67	Plumbing lower level	1999	21,177	1,059	20	1,059		2,647	67
68	ECU Awnings	1999	3,994	266	15	266		666	68
69	Paneling	1999	7,309	1,462	5	1,462		3,654	69
70	TOTAL (lines 4 thru 69)		$ 1,676,992	$ 102,233		$ 102,233	$	$ 974,771	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,676,992	$ 102,233		$ 102,233	$ 0	$ 974,771	1
2	Security System,Elevator	1999	11,010	734	1999	734		1,835	2
3	New door hardware	1999	197	20	1999	20		49	3
4	Fire alarm system upper level	1999	12,491	500	1999	500		1,249	4
5	Water Heater	2001	767	153	2001	153		230	5
6	Air Curtain	2001	764	153	2001	153		229	6
7	Replacement Parts - Boiler	2001	5,290	1,058	2001	1,058		1,587	7
8	Compressor Pump	2001	1,599	320	2001	320		480	8
9	Security Door	2001	2,427	485	2001	485		728	9
10	New Flooring	2000	2,955	591	2002	591		1,477	10
11	Roof Repair	1999	8,800	1,760	2002	1,760		6,160	11
12	Compressor Parts	1999	2,580	172	2002	172		602	12
13	Awnings	1999	2,520	504	2002	504		1,764	13
14	Boiler repair	1998	2,675	535	2002	535		1,873	14
15	Plexiglass-reception area	2002	3,100	310	2002	310		310	15
16	Stairwell Door replacements	2001	1,165	117	2002	117		117	16
17	New Radiator for generator	2001	3,002	300	2002	300		300	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,738,334	$ 109,945		$ 109,945	$ 0	$ 993,761	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 588,895	$ 117,334	$ 117,334	$	5	$ 421,766	71
72	Current Year Purchases	41,300	4,582	4,582		5	4,582	72
73	Fully Depreciated Assets	405,787					405,787	73
74								74
75	TOTALS	$ 1,035,982	$ 121,916	$ 121,916	$		$ 832,135	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2000 Internat'l Bus	2000	$ 62,500	$ 12,500	$ 12,500	$	5	$ 31,250	76
77	Maintenance Use	2000 Isuzu Truck	2000	31,007	6,201	6,201		5	15,503	77
78	General Use	2000 4-dr Chrysler Sedan	2000	26,000	8,667	8,667		3	21,667	78
79										79
80	TOTALS			$ 119,507	$ 27,368	$ 27,368	$		$ 68,420	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,925,323	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 259,229	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 259,229	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,894,316	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land Improvements (1990-2001)	$ 35,214	$ 3,647	$ 19,137	86
87	Build & Build Impr. (1990-2002)	862,828	50,634	453,229	87
88	Equipment (1990-2002)	136,471	27,255	136,471	88
89	Vehicles (1990-2002)	133,345	16,588	111,601	89
90	Leasehold Improvements	139,990	13,699	137,140	90
91	TOTALS	$ 1,307,848	$ 111,823	$ 857,578	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 9,536 Description: Office Equipment (Copy machines)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	87

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	44

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		418	2,567		2,985
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)	7,411	45,525		52,936
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 7,829	$ 48,092	$	$ 55,921
10	SUM OF line 9, col. 1 and 2	(e)	$ 55,921			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	42
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	
TOTAL TRAINED	49

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	line 39, Col. 8	13,140 hrs	289,080			85,933	13,140	375,013	12
13	Other (specify):									13
14	TOTAL			$ 289,080		$	$ 85,933	13,140	$ 375,013	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 7/1/01 **Ending:** 6/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,270,177	$ 1,270,177	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 66,502)	3,419,741	3,419,741	3
4	Supply Inventory (priced at Cost)	49,144	49,144	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	116,867	116,867	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Client related funds	519,836	519,836	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,375,765	$ 5,375,765	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,082,158	4,082,158	13
14	Buildings, at Historical Cost	5,576,450	5,576,450	14
15	Leasehold Improvements, at Historical Cost	319,570	319,570	15
16	Equipment, at Historical Cost	3,576,482	3,576,482	16
17	Accumulated Depreciation (book methods)	(6,729,833)	(6,729,833)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	11,456,562	11,456,562	21
22	Other Long-Term Assets (spe Board Restr.	1,270,502	1,270,502	22
23	Other(specify): Construction in Progress	5,234,175	5,234,175	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 24,786,066	$ 24,786,066	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 30,161,831	$ 30,161,831	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 862,315	$ 862,315	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	212,189	212,189	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,232	16,232	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Misc. Other Accrued	2,627,616	2,627,616	36
37	Client related liability	519,836	519,836	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,238,188	$ 4,238,188	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,238,188	$ 4,238,188	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 25,923,643	$ 25,923,643	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 30,161,831	$ 30,161,831	48

***(See instructions.)**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 21,185,516	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 21,185,516	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(794,851)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	5,950,279	11
12	Expenditures for Specific Purposes	(25,716)	12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Remaining Consolidated Inc./(Loss)**	(289,023)	15
16	Other (describe) **Change in Unrealized Gains/(loss)**	(102,562)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 4,738,127	17
	B. Transfers (Itemize):		
18	**Trf out of Restricted Funds into Operations-expenses**	(132,545)	18
19	**Trf out of Restricted Funds into Operations-Capital**	(4,704,563)	19
20	**Trf into Operations from Restricted-expenses**	132,545	20
21	**Trf into Operations from Restricted-Capital**	4,704,563	21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 25,923,643	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,941,951	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,941,951	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	1,397	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,397	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	57,998	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	11,437	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 69,435	23
	D. Non-Operating Revenue		
24	Contributions	24,936	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,936	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine/Cafeteria	1,256	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,256	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,038,975	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,047,283	31
32	Health Care	3,230,229	32
33	General Administration	1,589,475	33
	B. Capital Expense		
34	Ownership	268,765	34
	C. Ancillary Expense		
35	Special Cost Centers	375,013	35
36	Provider Participation Fee	323,061	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,833,826	40
41	**Income before Income Taxes (line 30 minus line 40)****	(794,851)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (794,851)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,976	2,080	$ 65,229	$ 31.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,124	25,394	581,059	22.88	3
4	Licensed Practical Nurses	8,230	8,663	170,394	19.67	4
5	Nurse Aides & Orderlies	118,277	124,502	1,550,660	12.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,382	1,454	28,205	19.40	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	2,964	3,120	46,966	15.05	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	39,749	19.11	13
14	Head Cook	5,928	6,240	78,000	12.50	14
15	Cook Helpers/Assistants	7,859	8,273	86,770	10.49	15
16	Dishwashers	1,976	2,080	21,816	10.49	16
17	Maintenance Workers	4,043	4,256	61,709	14.50	17
18	Housekeepers	11,856	12,480	100,771	8.07	18
19	Laundry	8,590	9,042	73,062	8.08	19
20	Administrator	4,025	4,237	132,706	31.32	20
21	Assistant Administrator					21
22	Other Administrative	13,214	13,910	284,780	20.47	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,840	10,358	156,724	15.13	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	7,110	7,484	61,870	8.27	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) RN-Exceptl Care	12,483	13,140	289,080	22.00	33
34	TOTAL (lines 1 - 33)	245,853	258,793	$ 3,829,550 *	$ 14.80	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	331	$ 16,485	1	35
36	Medical Director	Monthly	32,267	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	3	180	10a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	665	37,224	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	70	3,869	10	46
47	Dental,Vision,Pharmacy	various	4,893	10	47
48					48
49	TOTAL (lines 35 - 48)	1,069	$ 94,918		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	5,982	140,897	10	52
53	TOTAL (lines 50 - 52)	5,982	$ 140,897		53

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terri Bowen-Weyrich	Admin Support		$ 76,359
Tara McKennie	Administrator		56,347
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 132,706

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KPMG	Audit Fees	$ 10,349
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 10,349

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,910
Unemployment Compensation Insurance	15,395
FICA Taxes	292,961
Employee Health Insurance	258,669
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	139,049
Dental	21,345
Life Insurance/Disability	1,891
TOTAL (agree to Schedule V, line 22, col.8)	$ 820,220

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	49,115
Health Care Worker Background Check	
(Indicate # of checks performed)	
IHCA Dues	3,950
Misc. Licenses and Permits	6,170
Misc. Dues and Subscriptions	4,884
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 64,119

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,589
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,589

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/01 Ending: 6/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 7/1/01 **Ending:** 6/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assoc. $3,950

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Yrs.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 94,189 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 323,061
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes (NDSEC Rent) For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ N/A Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 15%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Marklund Children's Home
IDPH Facility ID Number #0011288
Fiscal Year 2002
Schedule V. Cost Center Expenses

Line #10 & Line #13

Reclassification:

Wages for the in-house trainer for our Nurses Aide Training Program: $52,936

Note: This is also reflected on Schedule XIII. Expenses relating to Nurse Aide Training Program

Line #21

Reclassification:

Rental Expenses for Office Equipment (Copy Machines) $9,536

Note: This is also reflected on Schedule XII. Rental Costs on Equipment

Line #33 & #34

Reclassification:

Real Estate Taxes reclassed from Rent-Facility to Real Estate Taxes on a rented site

Note: All Real Estate Taxes are ultimately adjusted out of the cost report when filed $9,690

Marklund Children's Home
IDPH Facility ID Number #0011288
Fiscal Year 2002
Schedule VI. Adjustment Detail

Line # 33

Adjustment: Non-Allowable

Real Estate Taxes: $11,949

Marklund Children's Home
IDPH Facility ID Number #0011288
Fiscal Year 2002
Schedule XX. General Information

Line #14

There is minimal space, (one classroom), that is rented to NDSEC to provide day school to some of our clients. There are no costs associated with this. NDSEC supplies their own teachers and supplies, etc. We generate minimal income for the rental of this room, $11,437, (reflected on Schedule XVII., Income Statement, Line #16).

Marklund Children's Home
IDPH Facility ID Number #0011288
Fiscal Year 2002
Schedule XIX. Support Schedules
Section G. Seminar Expenses

Date of Seminar	Name	Title	Location	Sponsor/Title	Amount
3/13/2001	LEMUEL PABLO	HABILITATION MANAGER	CHICAGO	CROSS COUNTRY SEMINARS	$149
4/1/2001	WES KOCHAN	RECREATIONAL THERAIPIST	INDIANA	ATRA	$197
7/24/2001	LEMUEL PABLO	HABILITATION MANAGER	SPRINGFIELD	IHCA	$85
8/9/2001	ERICA WHITTIEMOR	C.N.A.	NAPERVILLE	SKILL PATH SEMINARS	$149
8/9/2001	KEITH MARTIN	C.N.A.	NAPERVILLE	SKILL PATH SEMINARS	$149
8/9/2001	CHISTINE WILKINS	C.N.A.	NAPERVILLE	SKILL PATH SEMINARS	$149
9/19/2001	IRENE KASNICKA	DON	NAPERVILLE	CENTRAL DUPAGE HEALTH	$35
9/19/2001	PAT PETERMAN	DON	NAPERVILLE	CENTRAL DUPAGE HEALTH	$35
9/22/2001	TERRI BOWEN-WEYRICH	C.O.	SPRINGFIELD	IHCA	$675
9/22/2001	TARA MC KENNIE	ADMINISTRATOR	SPRINGFIELD	IHCA	
9/22/2001	ANGELO D'ANDREA	MAINTENCE	SPRINGFIELD	IHCA	
9/22/2001	CHERL VALDEZ	DIETARY MANAGER	SPRINGFIELD	IHCA	
9/22/2001	CECILIA HERNANDEZ	DIETARY SUPERVISOR	SPRINGFIELD	IHCA	
9/22/2001	MARIA LATERZA	DIETARY AIDE	SPRINGFIELD	IHCA	
9/22/2001	KIMBA BROWN	QMRP	SPRINGFIELD	IHCA	
9/22/2001	LAURA MAROUSEK	QMRP	SPRINGFIELD	IHCA	
9/22/2001	LEMUEL PABLO	HABILITATION MANAGER	SPRINGFIELD	IHCA	
9/22/2001	MYRA BERTLING	RECREATIONAL THERAIPIST	SPRINGFIELD	IHCA	
9/22/2001	WES KOCHAN	RECREATIONAL THERAIPIST	SPRINGFIELD	IHCA	
9/22/2001	JENNIFER GULBRANDSON	QMRP	SPRINGFIELD	IHCA	
9/22/2001	VICTORIA GILLESPIE	QMRP	SPRINGFIELD	IHCA	
9/22/2001	SUE RUSCO	P.T	SPRINGFIELD	IHCA	
9/22/2001	RANDY COOPER	QMRP	SPRINGFIELD	IHCA	
9/22/2001	DELORES LAWSON	C.N.A.	SPRINGFIELD	IHCA	
9/22/2001	AMY CHAMPMAN	GROUP HOME MANAGER	SPRINGFIELD	IHCA	
9/22/2001	TELLY MCNEAL	C.N.A.	SPRINGFIELD	IHCA	
9/24/2001	TERRI BOWEN-WEYRICH	ADMINISTRATOR	MLA	ANOTHER ANSWER	$149
10/3/2001	TERRI BOWEN-WEYRICH	ADMINISTRATOR	ROLLING MEADOWS	COMMUNITY EDUCATION	$90
10/5/2001	CHERL VALDEZ	DIRECTOR SUPPORT SERVICE	BLOOMINGTON	CHICKEN SOUP DMA	$75
10/5/2001	VICKY CORRIGAN	P.T.A	VILLA PARK	KINESIO TAPING IN PEDIATRICS	$380
10/17/2001	DIANE DOYLE	NURSE	DOWNERS GROVE	PESI HEALTHCARE	$135
10/24/2001	TARA MC KENNIE	ADMINISTRATOR	GLENVIEW	FRANKLIN COVEY	$279
12/4/2001	LEMUEL PABLO	HABILITATION MANAGER	NAPERVILLE	PADGETT THOMPSON	$169
12/4/2001	NANCY RODRIGUEZ	ASST.ADMINSTRATOR	NAPERVILLE	PADGETT THOMPSON	$169
12/11/2001	AMADA AMAYA	DIETARY AIDE	DOWNERES GROVE	PALADIN MANAGEMENT	$225
12/11/2001	VERONICA ARRELOA	DIETARY AIDE	DOWNERES GROVE	PALADIN MANAGEMENT	$225
5/9/2002	VICKY CORRIGAN	P.T.A	WILLOWBROOK	HANGER P &O	$25
5/16/2002	TARA MC KENNIE	ADMINISTRATOR	MLA	D.BOOK	$50
5/16/2002	JENNIFER GULBRANDSON	DIETARY AIDE	MLA	D.BOOK	$50
6/3/2002	NANCY RODRIGUEZ	ASST.ADMINSTRATOR	SCHAUMBER	SKILL PATH SEMINARS	$399
6/11/2002	PAT PETERMAN	SOCIAL SERVICE MANAGER	SCHAUMBER	CROSS COUNTRY SEMINARS	$149
6/17/2002	HOLLY MARSZALEK	NURSE	CHICAGO	SOUTHWEST SEMINARS	$49
6/17/2002	NANCY LESCH	NURSE	CHICAGO	SOUTHWEST SEMINARS	$49
6/17/2002	DIANE DALY	NURSE	CHICAGO	SOUTHWEST SEMINARS	$59
1/8/2002	JACKALYN AGUILAR	C.N.A.	BLOOMINGDALE	COD- TEAM BUILDING	$174
1/8/2002	LELAND AROMIA	C.N.A.	BLOOMINGDALE	COD- TEAM BUILDING	$174
1/8/2002	VERONICA ARRELOA	DIETARY AIDE	BLOOMINGDALE	COD- TEAM BUILDING	$174
1/8/2002	NORMA BACA	NURSE	BLOOMINGDALE	COD- TEAM BUILDING	$174
1/8/2002	ANGELA BEAL	C.N.A.	BLOOMINGDALE	COD- TEAM BUILDING	$174
2/28/2002	ROBERTO BENITOZ	HOUSEKEEPING	BLOOMINGDALE	COD- TEAM BUILDING	$145
2/28/2002	MYRA BERTLING	RECREATIONAL THERAIPIST	BLOOMINGDALE	COD- TEAM BUILDING	$145
2/28/2002	MELIVN BLAND	NURSE	BLOOMINGDALE	COD- TEAM BUILDING	$145
2/28/2002	SHARON BRECHIN	NURSE	BLOOMINGDALE	COD- TEAM BUILDING	$145
2/28/2002	KIMBA BROWN	C.N.A.	BLOOMINGDALE	COD- TEAM BUILDING	$145
2/28/2002	MARGARET BUTERA	VOL DEPT	BLOOMINGDALE	COD- TEAM BUILDING	$145
2/28/2002	FRANCISCO CASTELLANOS	HOUSEKEEPING	BLOOMINGDALE	COD- TEAM BUILDING	$145
2/28/2002	BRANDY CHAPMAN	C.N.A.	BLOOMINGDALE	COD- TEAM BUILDING	$145
2/28/2002	MARY CHOW	NURSE	BLOOMINGDALE	COD- TEAM BUILDING	$145
2/28/2002	LAURIE COLLES	NURSE	BLOOMINGDALE	COD- TEAM BUILDING	$145
2/28/2002	RANDY COOPER	QMRP	BLOOMINGDALE	COD- TEAM BUILDING	$145
2/28/2002	IGNACIO RIOS CORONA	HOUSEKEEPING	BLOOMINGDALE	COD- TEAM BUILDING	$111
2/28/2002	VICKY CORRIGAN	THERAPIST	BLOOMINGDALE	COD- TEAM BUILDING	$111
2/28/2002	ROSE COUSINS	NURSE	BLOOMINGDALE	COD- TEAM BUILDING	$111
2/28/2002	ANGELO D'ANDREA	MAINTENCE	BLOOMINGDALE	COD- TEAM BUILDING	$111
2/28/2002	KATHY DAEZ	C.N.A.	BLOOMINGDALE	COD- TEAM BUILDING	$111
2/28/2002	GLENDA DAVIDSON	C.N.A.	BLOOMINGDALE	COD- TEAM BUILDING	$111
2/28/2002	STEPHANIE DELLEGROZIE	C.N.A.	BLOOMINGDALE	COD- TEAM BUILDING	$111
					$7,589

Marklund Children's Home
IDPH Fadility ID Number #0011288
Fiscal Year 2002
Schedule XII. Rental Costs
Listing of Moveable Equipment

Description	Quantity
Minolta Fax 2600	2
Minolta D1550	1
Lanier 6720 AG	1